MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Friday, September 10, 2004

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Results of hospital charging practices survey
-- Chantal Worzala, Jack Ashby

DR. WORZALA: Good morning. I'm here to talk about a survey that was recently conducted on hospitals' charge setting practices.

MR. HACKBARTH: Can I just interrupt for a second? For those of you who are leaving, could you please do so quietly so as not to disrupt this presentation?

Thank you.

DR. WORZALA: We recently had a survey completed by the Lewin Group of hospitals about their practices in setting charges. Although I'm giving the presentation, Jack is here with me because he was also involved in the project.

The survey was motivated by a number things but primarily by the center role that charges play in how CMS is setting payment rates for hospital services under Medicare and also the lack of systematic data and information on how hospitals set their charges.

As Glenn just mentioned, this study is relevant to our work on specialty hospitals and it's also relevant to a mandated study that we have due next July on how we are paying for pharmacy services under the outpatient PPS.

Under the inpatient acute-care PPS, the relative weight for DRGs are based on average adjusted charges. On the outpatient side, once CMS sets payment rates it uses charges reduced to costs using cost-to-charge ratios from the cost reports. So you can see that the relationship of charges to payment rates is fairly direct.

On the inpatient side, if markups over costs vary across services the relative weights could well be too high for some services and too low for others.

More explicitly, where the markets are higher the relative weights would be higher relative to costs and vice versa.

On the outpatient side, the connection is a little bit less straightforward. However, given the methodology used, differences in markups across services can still affect the relative weights. I'm not going to go into detail about now but I'd be happy to talk about it later if you're interested.

The survey consisted of 57 structured interviews and the survey instrument is in your packet if you want to refer to it. Some of the interviews covered a single hospital while others covered a system where charges were set centrally for a collection of hospitals. In all, the interviews represent the charge setting practices of 251 hospitals.

The Lewin Group interviewed charge master managers and/or their supervisors in the finance department. The sample was non-random, although the contractor did try to make it representative by region, teaching status and ownership. Recruitment was quite

difficult for this study despite repeated assurances of anonymity.

The sample did have an equal representation by region, so Northeast, South, Midwest and West. But it includes a greater share of teaching hospitals than the national average and a smaller share of rural hospitals.

In addition, we found very few for-profit hospitals willing to participate and this may be due to the proprietary nature of the topic. We also ended up with few government-owned facilities.

We were looking at a number of areas in this survey and we included questions about the structure of the process hospitals follow when they set their charges. We were looking at the factors they consider, the relationship between costs and charges, and the information used to set charges, the extent of variations in markups across services and examples of where markups may vary.

We also focused on two areas that have received considerable policy attention recently, one being cardiac services and the other pharmaceuticals.

The rest of the slides will present the major themes emerging from the survey. As a caveat, I want to note that this was a qualitative study and we're sharing general impressions from the 57 structured interviews that were conducted.

Regarding the structure of the process, we found that hospitals maintained a database of services and items that they supply to patients and they attach charges to each item. This is called the charge master.

Charge masters are large and complicated and they encompass tens of thousands of items. As I'm sure you know, the Medicare program requires participating hospitals to maintain one set of charges that apply to all payers. That's what's in the charge master.

Hospitals set their charges for individual services and items. This slide gives some examples, such as a daily room charge, charge for an x-ray, the charge for a block of minutes of operating room time, the charge for an individual supply, be that bandages of some sort or a cardiac implant, and charges for a particular dose of a drug.

Hospitals do not set their charges for the bundles of services that Medicare pays for, that is the DRGs or the APCs, nor do they generally set them for a different bundle such as admission or an ambulatory surgery. Rather hospitals bill for an individual patient the charges for each of the services or items that they have offered during the stay or the encounter. These bills are then later classified into a DRG or an APC.

So the charges that we are using when we set payment rates for a DRG or an APC will vary both by the patient and by the hospital.

The process of setting charges is generally overseen by the finance department but involves most hospital departments to some degree as charges are set for each department's services.

Hospitals generally change their charge master for one of three reasons. First, there is often an annual update or

increase in charges which accounts for cost increases or to satisfy other financial goals. These increases are not necessarily uniform across departments. Some departments may see a higher across-the-board increase than others.

Second, on an ad hoc or periodic basis, hospitals will review and revise some of their existing charges. Sometimes they will look at all the charges for a whole department but more often they modify the charge for a specific service or set of services that have been noted to be problematic. An exhaustive review of all of the charges is very rare due to the large number of charges in the charge master.

Finally, hospitals do modify their charge master to add new services.

A major theme arising from the interviews was that setting charges is a core business function. As such hospitals are responding to many different pressures and balancing many different calls when they set and modify their charges. Some of those factors include accounting for changes in cost, both overall and for an individual service or item. In addition, they think about the financial goals that they have. They also think about other missions which may, as previously discussed, include the need to cross-subsidize some services with others.

Hospitals also face competitive pressures that they factor into their charge setting, both from other hospitals as well as from ambulatory settings such as ASCs.

Hospitals also have to consider their arrangements with payers, which range from discounts off charges to per diems or fee schedules or capitation. And depending on the relationship with payers, charges may be more or less important to a hospital.

Hospitals also take community perceptions of the fairness of their charges into account.

Another theme that emerged from the interviews involved the relationship between costs and charges. When asked an open-ended question about the information they used to revise existing charges only half of the hospitals mentioned costs. Hospitals indicated that they use many other sources of information as well, including public data, market information, advice from consultants as well as information from their payers which would include Medicare's payment rates.

So you might get a little circular issue of using Medicare to set charges and charges to set payment rates.

Hospitals reported that costs do play a greater role in setting charges for supplies and pharmaceuticals as well as for new services. And on supplies and pharmaceuticals we did find most hospitals reporting using a formula or a table where they developed their charges based on the costs of the items. These formulas generally contain cost categories with the size of the markup over costs depending on the cost of the item.

The survey had a set of questions on variations in markups by service and hospitals reported that markups can vary by service for a number of reasons such as payer mix, utilization and market forces. One of the most cited examples of variation would be that low-cost items have higher markups than high-cost items. Some of that has to do with the notion of sticker shock.

If something is very expensive and you mark it up a lot, it becomes very, very expensive.

Other than that, responses concerning how markups vary were not systematic across all the hospitals. But when asked to provide examples of services with low markups, some hospitals mentioned room and board and other visible services. Examples of services with high markups included outpatient and diagnostic services.

Interestingly, some hospitals reported that they no longer charge at all for very low-cost items such as aspirin.

The instrument contained a set of questions about charges for cardiac services and we have heard anecdotally that these services are more profitable than others under Medicare, as we were just discussing under the specialty hospital study. One way that could be possible is if the services that make up the cardiology DRGs had systematically higher charges than other services. If that were true, then the relative weights for cardiac DRGs under the inpatient PPS would be higher in comparison to costs than the relative weights for other DRGs.

However, hospitals reported using the same process for sitting their cardiac charges as for other services. One exception is that some hospitals with a catheterization lab develop charges for an entire procedure rather than billing for minutes of the operating time and other inputs as they generally do when something is done in the operating room.

Although hospitals report using the same processes to set charges for cardiac services, responses to other questions do suggest that the services may receive closer attention. First, many cardiac services receive high dollar values which hospitals said they often look at more closely. In addition, many of the cardiac procedures are new.

The survey also focused on charges for pharmaceuticals for a couple of reasons. First, setting payment rates for drugs has been very problematic under the outpatient PPS. In addition, we have a mandated study to consider whether or not there should be a payment adjustment in the outpatient PPS to cover pharmacy services other than the actual cost of the drug. That study is due in July 2005.

We found that hospitals reported charges for pharmaceuticals as being handled separately and often with considerable involvement of the pharmacy director. Almost unanimously the hospitals reported that they have one charge that covers the cost of acquiring, preparing and storing each drug. They do not have separate charges for their pharmacy services.

About three fourths of the hospitals reported using a formula based on acquisition costs or average wholesale prices where they converted costs into charges. Some of the more sophisticated formulas might also vary the markup by the type of drug or the route of administration, is it oral or is it IV, or the form of preparation, are they starting with a pattern or a liquid? In most of these formulas hospitals reported that lower cost items have higher markups than higher cost drugs.

So I've presented you with a number of findings from the survey and this slide summarizes the major points. The charge

master is large and complex. Hospitals are weighing numerous factors when they set their charges such as financial goals, other missions and competitive pressures.

The survey results suggest that there is no systematic relationship between costs and charges but that is more likely for supplies, drugs and new services than for other existing services.

We also found that markups can vary by service. The most common example was low-cost items having a higher markup than high cost, as I've said. The other examples were not systematic across hospitals.

The findings of the survey are relevant to several of our studies. You just heard about the analyses being undertaken for our mandated study on specialty hospitals. Another analysis that will be done will compare the relative weights for DRGs that result from using charges versus an approach of using charges reduced to costs.

In addition, questions on charges for the pharmaceuticals will be appropriate for our mandated study in that area.

And finally, we also have a project to model CMS's approach to setting payment rates under the outpatient PPS and we will try to look at alternative approaches for setting payment rates that might, for example, adjust in some way for this difference in markup between high and low-cost items.

I'll take your questions.

DR. CROSSON: Chantal, do you have any information on how other countries such as Canada or the U.K. or Switzerland would handle payments to hospitals in relation to their costs? How they calculate an appropriate payment?

DR. WORZALA: It's going to depend on the country, and I'm going back to information I learned many years ago, but in Canada a lot of it is I believe budgeting and negotiation. I actually am not sure about what happens in England now with the GP fund holding, whether the hospitals discharge. I honestly don't know.

DR. CROSSON: I wondered if they had anything analogous to a cost report that formed the basis for beginning their negotiations and whether indeed they based it, for example, on acquisition costs plus a percentage rather than just sort of taking a stab, like we appear to be.

DR. WORZALA: I can look into that but I can't answer right at the moment.

MR. DURENBERGER: A question or two on the charge side and then one question on the cost side.

On your slide, PowerPoint number seven, the hospitals balance many factors when setting charges. One of them was arrangements with payers. I wonder if you wouldn't just talk about that a little bit.

And then another question occurs to me, and that is would not Richard Scruggs have a lot of information that might be valuable to us, if you follow my question?

DR. WORZALA: On the arrangements with payers, the importance of charges really depends on whether or not charges play into reimbursement for the hospital. So if the hospital has a lot of contracts where it discounts off of charges, they'll

spend a lot more time thinking about their charges than if they have a lot of capitated arrangements or where they are responding to a payer's fee schedule or a negotiated per diem rate.

MR. DURENBERGER: I know you're not an expert, nor am I, on the lawsuit against nonprofit hospitals and so forth but is there not something to be explored there that would be informative? I'm just asking the question because I don't know the answer.

Obviously, they are digging into some of this same kind of an area, I would assume.

DR. WORZALA: I think both have to do with how hospitals set their charges but I think there's a pretty key distinction where what we're really looking at it is pretty much relative markups across services and how that plays into Medicare's process of setting payment weights. We don't care so much about the absolute level of the charge because when Medicare is setting its payment rates it all becomes a set of relatives.

Whereas when you're thinking about what the uninsured pay, for example you really care about the absolute level of the charges much more than the relatives across services. So I think that would be the key distinction.

MR. DURENBERGER: My other question relates, and again I don't know the answer to it and I don't even know if it's relevant. And that is the group purchasing organizations. Again, I don't know exactly how they operate except that there has been some suggestions over the last year or two that something is going on, and I don't know what it is, between certain of the group purchasing organizations and their members. And it varies from one to the other kind of a member.

Is there anything in there that is of value to us in determining what is actual cost to the hospital?

DR. WORZALA: That's an interesting point. I can certainly look into it. I'm not sure how hospitals would translate that into their charges but certainly it could help us understand hospital's costs.

MR. MULLER: While the chapter and your presentation showed that a lot of these hospitals do in a very incremental way, we also have seen evidence in the last few years, at least in the press, about one chain at least that seemed to have doubled its charges routinely, and so forth.

Remind me again, what's the relative advantage or disadvantage of having charges of like 10 times cost versus just a little bit above cost? So if somebody has charges that are like -- let's say your cost-to-charge ratio is 10 percent versus 90 percent. Are there any, off the top of your head, advantages of a place that has charges that are 10 times higher than costs?

I know there's that kind of short-term advantage for that chain, in terms what are the systematic reasons one might want to have charges being a big multiple of costs?

DR. WORZALA: Most of it pertains to non-Medicare.

MR. MULLER: I know about Medicare.

DR. WORZALA: Within Medicare, the only way -- and Jack can correct me if I'm wrong -- but I think the only way that that's going to play into how much you're paid is in the pace with which you increase your costs and that will determine outlier payments.

So as we've discussed in the past, if you're increasing your charges much faster than your costs and you have this time lag in the cost-to-charge ratio that CMS is able to use to adjust your charges to costs when calculating outlier payments, you will have an advantage there.

I guess the other thing that I would say is hospitals with higher --

MR. MULLER: Any sense of magnitude of that? I understand that have a one year lag but how much is this worth to a hospital? And if you double or triple your charges the day a new administration walks in, is that worth 5 percent or 10 percent per year? Do you have any sense of magnitude?

DR. WORZALA: I'll let Jack answer that.

MR. ASHBY: One thing I think that we have to make sure that we understand is that outliers is really the only area where it makes any difference. On all of the other allocations, the costs and the charges are for the same period of time so it literally does not matter how much the markup is because the cost-to-charge ratio adjusts for it directly.

Within the outlier arena, I think that we should add that CMS has made some substantial moves to reform the system so that they are more closely aligning the time period of the charges and the costs also to get to the point where it will also make very little, if any, difference in the outliers that hospital gets.

So that's the goal, is to get to the point where they're exactly the same and it won't make any difference.

MR. MULLER: At least that one chain seems to have had -- I'm sure there's other reasons as well -- a considerable collapse of its financial fortunes with the changes in the outlier policy. So if you're basically saying that we're pretty close to not being able to gain the system any more, is that the inference I should take from that?

DR. MILLER: I don't think we're saying that. I guess what I would answer in this situation is they have clearly tracked on the example where it was an advantage and that, given that the cost reports lag behind the charging practices, you could clearly game on that front.

As Jack said, CMS has moved in to deal with that. I think what I would like to do with this question is I would like to actually think about it. It is correct that when you have the cost reports from the same time periods, in theory when you track through you should, in fact, be relatively close. And then for Medicare purposes -- and this goes to Chantal's point about there may be other reasons to do that -- you should be relatively close.

But I also think this goes to the question you were asking in the last session, which has to do with the issues around recalibration and do we truly understand why some DRGs remain profitable and others don't, if that's in fact what our empirical work turns out?

So I think there may be a couple of issues, even inside that process, that we either need to think through to answer this question or maybe we're not yet aware of in answering.

So I just don't want to end up with a flat statement of we've basically eliminated the gaming possibility here.

DR. WORZALA: I wanted to get to that second part which is just to say that hospitals with higher overall charges will have more weight in setting the relative weights because you're taking averages. So the bigger numbers have more weight. So in that way the relatives, in their charges, will have some influence on the relatives across the system. We need to think about and diagnose that but that would be the logic.

MR. HACKBARTH: It's different from the outlier situation. The outlier situation, especially pre-reform, you could immediately directly benefit yourself as opposed to what it's all blended into the relative weight process the benefit to your institution is vastly diluted.

DR. REISCHAUER: Dave and Ralph brought up the two of the three topics I wanted to talk about but you gave, Dave, a less specific answer than I had hoped for. What I sort of want to know is for an average hospital how much of the revenue is dependent on charges as opposed to these other relationships? And I know it sort of varies around.

But the way you described it it's really a very minor fraction of the total. Because you have Medicare, you have Medicaid, you have many big insurers are paying on a capitated basis, on a DRG basis, or adjust DRG basis, something like that. I don't know whether this is the tail on a very fat dog or it makes a difference. Why don't we do issue one?

DR. WORZALA: I think that is going to vary a lot by hospitals. I think some of the hospitals that we spoke with did indicate that charges are becoming less important to them. But there are still services and you may find that, for example, your services weren't being paid discounted off charges or a specific set of services. It's less likely to be the services the elderly provide, for example, as the services that the uninsured and the people who are insured by smaller insurance companies.

DR. REISCHAUER: But the uninsured, 60 percent of them aren't paying their bill anyway. So what does it do, determine your bad debt? What I'm wondering is is this 20 percent or 60 percent?

MR. MULLER: The APCs really haven't come to the private outpatient side as fully yes. So for example, you're right, the insurers by and large, after 20 years, have picked up the DRG system for inpatient but they haven't really picked it up yet on the outpatient side, by and large. So charges still make a difference on privately insured outpatient, by and large. That's still the big open field for charges.

DR. REISCHAUER: The second thing was with respect to outliers and you answered a lot of the questions I had. But that raised sort of the question about the sample that Lewin talked to. And I wondered if anybody went through those hospitals and just checked -- if Lewin did because I know we aren't supposed to know who they are -- and checked where they were, in a sense, on their dependence on outlier patients and whether you didn't get participation by that subgroup of hospitals that, in fact, has shall we say gamed the outlier system and so we really have a

biased sample of the honest guys here.

The third issue was, if I read this right, this gets to Mark's inquiry. A hospital spends a lot of time working out charges for the little things that come in because they're relatively easy and for new procedures. And if the costs of new things follows the pattern that you see in most of the economy, they are relatively expensive when you begin doing them. Then you learn how to do them and you specialize and all of this, and the prices, the cost of it goes down.

And the hospital goes back and it reviews the things where the costs are going up and there's sort of a problem. But it would never review the things that costs are going down on unless there's sort of competitive pressure or something like that. And that's where we get into things like the cardiac area.

Is there any way we can look at two or three different areas where there's been a lot of technological advance in the procedure that we think will lead to lower cost? Laparoscopic surgery kinds of things and things like that where maybe this is where the margins exist that can cross-subsidize the other things.

MR. HACKBARTH: Was there anything in the survey results to the question of whether charges for some services actually do decline due to growing scale, experience and the like? Did anybody address that?

DR. WORZALA: We didn't address that specific question but we asked them why, what do they pick to change? And that certainly never came up as an example.

MS. DePARLE: I was going to make a different point sort of related to what Bob was asking. I think there's something circular here, a lot of circular things.

I don't think I fully understand the extent to which charges influence the DRG process at bottom because I think they do. I think it's probably going to turn out that it's always in the hospital's interest to have higher charges, even though we're kind of focusing on this cost-to-charge ratio issue as it relates to outlier payments.

To the extent that other payers -- Bob, you were suggesting that other payers have moved to these same sorts of systems. But many of them are based on DRGs. So underlying all of this is some building block that may or may not be quite influenced by how high you set your charges.

DR. REISCHAUER: I think, as Chantal said, it's just that in the great scheme of things you have a slightly higher weight in figuring out what the DRGs' weights are then you would otherwise, right?

DR. WORZALA: The logic of how the relative weights are set, where you're taking the average adjusted mean charge so you're taking out the wage index, you're taking out the teaching and the IME which, if those are things are done correctly you're taking out those influences in the charges. What you're really thinking about is the relative between one DRG and another.

So what will really influence, if you want to think about the profitability of one DRG versus another, is the relative markup over costs of the services in one DRG versus the services

in another. Nobody sets charges for a DRG, so you can't talk about the charge for the DRG but you talk about the bundle of services within that DRG. And that's the most direct.

I think we do need to do some more thinking about the influence of higher charges and escalating charges in that process.

MS. DePARLE: Maybe it goes so far back that it isn't relevant but weren't the original DRGs partly based on historical charges?

DR. WORZALA: My understanding is that when the weights were set the first time it was charges reduced to costs. And then with the first recalibration they went straight to a charge-based methodology.

DR. MILLER: At the time they felt that the correlation between charge-based weights and cost-based weights were the same. One of the issues that we're going to be taking apart when we think about the profitability of DRGs is to begin to see if we can look into that.

To my point earlier on this line of questions, and to the point where if you engaged in charging practices can it have a big impact? Remember, all of this travels through a cost-to-charge ratio which are based on different revenues which, as Chantal said, are not directly aligned with the DRG.

So the impacts of raising your charges for certain services is probably hard to track through and probably very specific to a hospital. They may feel, and this survey says that hospitals are engaged in a lot of different behaviors. They may feel that there's a certain set of services that if they raise the charges on they'll see the effects. And the effects could come through in the Medicare payments but that's probably hard to see and judge and know in advance, although you might establish it over time as a hospital.

Certainly the private site has been acknowledged by everybody. We've acknowledged the outliers. Bad debt payments might be influenced by this.

You made a statement if there at the margins --

MS. DePARLE: So would there ever be an incentive to ever do anything other than have higher charges? And have you ever found an example of charges that have been lowered? You asked the question of over time if services diffuse or whatever.

I would suspect you're not going to find that.

I'm probably making this too complicated, but I just think it's human behavior. This is all so complicated, so why would any hospital ever assume it was in their interest not to increase charges?

If they aren't doing it for any untoward reasons.

DR. WORZALA: The conversations we've had leave me with the impression that a charge is set and then it stays unless there's a problem and it simply gets increased annually. I don't know of Ralph or others have other...

DR. WOLTER: On the question of do hospitals ever reduce charges, yes, on rare occasions. But they are rare and it would have to do with recognition that out-of-pocket expenses have gotten very, very high for a given procedure. That might be an

altruistic reason to do it.

And there are some cases also where ASCs or others come into a market and to be competitive in your outpatient department you really do go and try to make some adjustments downward. But that is certainly not commonly done.

I was just going to give an example from our place for whatever that's worth. We, on the inpatient side, are just over 50 percent Medicare, 50 or 55 percent. We probably have 25 or 30 percent of our inpatient business that's commercial. Some of that's discounted and some of it's discounted heavily. Some of it is actually based on payment methodologies that's not related to our charges.

This is my observation of our finance department's behavior on charge setting. They are looking at that 25 or 30 percent of business more than they're looking at Medicare. Because when you raise your charge, at least for the short run, your Medicare reimbursement is not affected and people are not thinking about three year or so cycle of re-weighting of DRGs as much as they are about how to get out of the margin problem they're having in their given fiscal year.

So when those behaviors occur over 15 or 18 or 20 years, which they now have since DRGs were originally put in place, their actual relationship between your costs and your charges really does start to change considerably.

And to the extent that the commercial payers pay you very well in cardiology, orthopedics, neurosurgery, et cetera, you reinforce in the Medicare system, through your behaviors of creating charges aimed at the commercial market, weights that then drive payment that are also a bit better in the Medicare system.

So my question has been, as we do this study, will we find that that, in fact, tends to be the fact as we get more and more information? It's sort of also my thesis.

I think the issues that raises are when we look at individual DRG profitability, which we did to some degree in the transfer conversation, we may not be looking at very good information on individual margins anymore because those cost-to-charge ratios have gotten so distorted over the years.

But more importantly, we just had a big conversation about specialty hospitals and the focus on physician behavior. In the not-for-profit world there are huge strategic decisions and capital allocations being made around where the profitability is. And huge, huge decisions about ortho and heart hospitals. And those behaviors are very strong right now.

And yet, if you really want to look at how we might want to apply resources into geriatrics or mental health or these non-surgical areas, right now the payment system, I think, is driving us in a direction that maybe doesn't balance how we might want those resources to be allocated.

So this is very complex and it's very hard to get this data but the importance, I think, is significant if we can get a sense of how we might chart a new that direction.

MR. HACKBARTH: I think your observation, Nick, that this is not just sort of a one-time problem but actually it accumulates

potentially the errors, the disconnect accumulates over time.

For example, one way it might would be a service that's initially expensive when it's new. But as it expands in size and experience the costs come down but the charges always stay up. And you do that over a 20- year period and you're problem could be getting dramatically worse over time, as opposed to the disconnect being relatively constant.

MR. MULLER: Can I just make a narrow point on that among the several very good points that Nick made. I'd like to at least follow up on one in terms of what we can analyze, which is I agree with him that the behavior of not-for-profit hospitals is especially much more shaped by the opportunities on the private site than by Medicare because of the administrative pricing in Medicare.

On the other hand, if you do have 20 years of higher charges in neurosurgery and orthopedics and heart care and so forth, I'll go back to the question that Jack took a crack at earlier. Does that have an effect on the DRG weighting in a cumulative way? And perhaps doing some arithmetic simulations of that might be worth it because it's not hard to figure out that people with heart disease and prostate cancer tend to be better insured than women who are 17-years-old and deliver babies. They're just better insured and you have higher charges and so on. And so after 10 or 20 years there are higher charges in heart care than there are in delivering of children.

Does the cumulative effective 10 or 20 years of that have an effect on the DRG rating? I think that is worth looking at. And whether we want to do some arithmetic simulation of that, it may be worth doing to see -- I grant Jack's point that it has more to do with outlier policy but there may just be some skewing that we should look at.

DR. MILSTEIN: My comments are somewhat overlapped with Ralph's. Two comments.

Number one is, as Ralph was suggesting, the answer to this question is modelable. That is both for Medicare and for non-Medicare we can establish a quantitative sensitivity of the impact of a dollar increase in charges on how much Medicare in the next year pays you and how much non-Medicare payers pay you in the subsequent year.

There's a relationship there that relates to Bob's question that relates to the size of the tail and the size of the dog. We don't know that but I believe it is modelable.

Secondly, it would help me to get clear on the scope of the question we're asking. We could have a narrow scope question, which is post these adjustments that have just been made on gaming outlier policy, what is the remaining sensitivity of how much Medicare pays to every dollar increase in charges? That's a narrow question.

The bigger question is what are the indirect effects on the Medicare program intermediate-term related to whatever sensitivity does or does not exist with respect to charge increases that hospitals make with respect to non-Medicare payers?

One could make the argument, I think Ralph referred to for

example the ambulatory non-Medicare areas -- this is not your exact words -- but the last sort of arena of unconstrained hospital charge setting or price setting that has some significance for revenue.

What does that do for the Medicare program intermediate-term to have -- I'll call it from a purchaser perspective an unguarded frontier, as it were, in terms of where there's a lot of remaining price flexibility, a lot of payment systems based on charges minus X percent?

That does have impacts intermediate on Medicare because to the degree hospitals do not feel price constrained in any important dimension in their revenue stream, their incentive to seek the kind of efficiency capture that the IOM is talking about is reduced. And that then has implications for the Medicare program.

So it would help me to understand whether or not we're trying to, through our analytics and our modeling, answer the narrow question or the broader question that would include indirect feedback loops on the Medicare program from less charge flexibility on the part of hospitals with respect to non-Medicare payers.

MR. HACKBARTH: Others can respond but my feeling is that we've been talking primarily about the former. We're worried about the direct impacts on the Medicare program and its mechanisms for setting prices and therefore differential profitability and the like, as opposed to the broader second issue.

This has been a helpful conversation for me. I think on the one hand my impression is that the opportunities for individual hospitals to game the charging system are primarily in the area of the outlier payment and they have presumably been reduced, at least somewhat, by the steps that CMS took.

On the other hand, I think it still may be true that Nick is right that, although it's not conscious gaming activity, just normal human behavior means that accumulating errors over 20 years could mean that this important tool in the Medicare system is getting more and more out of whack.

I don't think those are mutually exclusive possibilities.

Any other questions or comments?

Okay, thank you.